

Attachment A

TREATING PHYSICIAN'S CLEARANCE TO RETURN TO WORK

NOTICE TO EMPLOYEE: Use of this form is voluntary. However, having your physician complete this form will facilitate your clearance to return to work by the Health Services Division. If you do not wish to have your physician complete this form, call the Health Services Division at 527-7024 to schedule an appointment for a return to work evaluation.

THE FOLLOWING SECTION TO BE COMPLETED BY EMPLOYEE

I have read the above notice and understand the use of this form is voluntary. I am electing to use this form and I authorize my treating physician to complete this report and to provide the City Health Services Division with appropriate copies of my medical reports. Further, I authorize my treating physician to discuss pertinent issues regarding my treatment with the City's designated physician or examiner so that my clearance to return to work can be timely processed.

Employee's Signature: _____ Date: _____

Employee's Name: _____

Department: _____

Position: _____

THE FOLLOWING SECTION TO BE COMPLETED BY TREATING PHYSICIAN

The above employee has been under my professional care due to:

(describe injury or illness)

and was incapacitated from work from: _____ to _____
(beginning date) (ending date)

WAS THIS A WORK RELATED INJURY? YES ☐ NO ☐ WAS THE EMPLOYEE HOSPITALIZED: YES ☐ NO ☐

Name of hospital and reason for hospitalization: _____

DID THE EMPLOYEE HAVE SURGERY: YES ☐ NO ☐

Describe the surgery: _____

DOES THE EMPLOYEE REQUIRE FURTHER TREATMENT OR THERAPY: YES ☐ NO ☐

Describe type, frequency and duration: _____

HE/SHE IS RELEASED TO RETURN TO WORK AS FOLLOWS EFFECTIVE: _____ (date)

Full Duty with no restrictions ☐

Modified (limited) duty with restrictions outlined below ☐

Summary of work restrictions and other comments as appropriate:

PLEASE ATTACH SURGERY, MRI OR X-RAY REPORTS AS APPROPRIATE

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____ PHONE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

INSTRUCTIONS FOR DEPARTMENT:

If you require a return to work evaluation by the Health Services Division, forward this form along with a copy of the employee's position description and physical effort analysis to the employee so the treating physician can review and complete this form. After receiving and reviewing this form, the City's designated physician or examiner will determine if it will be necessary to see the employee or if the employee can be cleared based on the information contained on the form.

INSTRUCTIONS TO EMPLOYEE:

This form must be reviewed by the Health Services Division prior to returning to work. Please sign the authorization on the first page and have your physician complete this form and mail or deliver to the following address:

City and County of Honolulu
Health Services Division
840 Iwilei Road
Honolulu, Hawaii 96817

This form may also be faxed to (808) 522-7057. Do not return the form to your department.

INSTRUCTIONS TO PHYSICIAN:

Due to the nature of this employee's work, the employee's department requires a review by the Health Services Division prior to returning to work after an extended absence. Please assist us by completing this form, attaching appropriate x-ray and surgical reports, and mail, fax or have the employee hand carry directly to the Health Services office. Due to the confidentiality of employee medical and health records, the form should not be returned to the employee's department. Thank you for your assistance.